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Foreign Aid and Donor Support: An Assessment of Current Campaigns against the Spread of HIV and AIDS in Botswana

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ABSTRACT

The following study seeks to address the current complexities and relationships between donor funding and program structure within the context of HIV and AIDS in Botswana. The study examined local conditions that exist throughout the country in terms of program effectiveness, sustainability, and efficiency as well as the relationship between funding structure and Batswana community engagement. Research was conducted over the course of seven weeks at the Botswana Christian AIDS Intervention Program (BOCAIP) in the capital city of Gaborone, and was followed by analysis. By examining the relationship between these two entities (foreign aid policy and funding structure), solutions were identified, thus helping to bridge the gap between funding and practice. The study concludes that community engagement based on local values, customs, and tradition was crucial to effective program implementation.

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LIST OF ABBREVIATIONS

ABC- Abstain, Be faithful to One Sex Partner, and Use a Condom
ACHAP- African Comprehensive HIV and AIDS Program
AED- Academy for Educational Development
AIDS- Acquired Immune Deficiency Syndrome
ARV- Anti-retroviral
BOCAIP- Botswana Christian AIDS Intervention Program
BONASO- Botswana Network of AIDS Service Organizations
BONEPWA- Botswana Network of People Living with HIV/AIDS
BOTUSA- Botswana-United States Partnership
CDC- Center for Disease Control
CIDA- Canadian International Development Agency
CIEE- Council on International Educational Exchange
CSO- Civil Service Organization
DFID- Department for International Development
FHI- Family Health International
HCT- HIV Counseling and Testing
HIV- Human Immuno-deficiency Virus
HPP- Humana People to People
IFI- International Financial Institution
IMF- International Monetary Fund
MCP- Multiple Concurrent Partnership
NACA- National AIDS Coordinating Agency
NGO- Non-governmental Organization
NORAD- Norwegian Agency for Development Cooperation
NSF- National Strategic Framework
OVC- Orphans and Vulnerable Children
PCI- Project Concern International
PSI- Population Services International
PEPFAR- President's Emergency Plan for AIDS Relief
PHC- Primary Health Care
PLWHA- People Living with HIV and AIDS
PMTCT- Prevention of Mother to Child Transmission
SAP- Structural Adjustment Policy
SIDA- Swedish International Development Agency
SM- Social Marketing
STD- Sexually Transmitted Disease
TB- Tuberculosis
UNAIDS- Joint United Nations Programme on HIV/ Acquired Immune Deficiency Syndrome
UNICEF- United Nations International Children's Education Fund
USAID – United States Agency for International Development

TABLE OF CONTENTS

Contents **Page**

CHAPTER 1

INTRODUCTION

1.1 Background Information

Now, in its fourth decade of the AIDS epidemic, the world has at last turned a corner, having halted and now commenced reversal of the spread of HIV. The epidemic peaked in 1999, after which the number of new infections fell by 19% globally, with 5 million people now receiving HIV treatment. By the end of 2009, 37% or approximately 4 million individuals received antiretroviral care in Africa with about 43 countries in the region providing HIV testing and counseling services. In 33 countries (22 of which are located in sub-Saharan Africa), HIV incidence fell by more than 25% between 2001 and 2009. New HIV infections are declining in many of the countries most affected by the epidemic. Fewer people are becoming infected with HIV, and fewer people are dying from AIDS compared to just a decade ago. (UNAIDS 2010)

The overall growth of the global AIDS epidemic appears to have stabilized now, over 30 years since the AIDS epidemic was first recognized (UNAIDS 2010). These gains are real but fragile. Despite extensive progress on a global scale, many countries individually will still fail to reach the Joint United Nations Programme on HIV/Acquired Immune Deficiency Syndrome's (UNAIDS) "Millennium Development Goal number 6." The UNAIDS program has developed many goals as part of the United Nations Millennium Declaration. This declaration is endorsed by 189 countries and is committed to a new global partnership aiming to reduce extreme world poverty by 2015 including "Millennium Development Goal number 6," which specifically aims to stop and reverse

the spread of AIDS (UNAIDS 2010). There are currently more than 33 million people living with HIV and AIDS worldwide with over 95% of AIDS cases and deaths occurring outside the United States ("History of HIV/AIDS," 2007). AIDS is the fourth leading cause of death worldwide and the number one cause of death from infectious disease (Healthcommunities.com 2007). It has surpassed malaria as the number one killer in Africa, and although the number of annual AIDS-related deaths worldwide is steadily decreasing, there still were an estimated 1.8 million lives lost in 2009 (UNAIDS 2010). In terms of HIV counseling and testing, although the availability and utilization of HIV testing and counseling services has increased substantially, more than 75% of individuals aged 15-49 in the African region do not know their HIV status (WHO 2011). Condom use among young people remains low and stigmatization, discrimination, and criminalization continue to impede the widespread effectiveness of interventions (WHO 2011). In addition to these hindering factors, is the reality that growth in investment for the AIDS response leveled for the first time in 2009 (UNAIDS 2010). The need for funding is now outstripping supply.

The pandemic is far from over. Botswana, a nation of around 1.7 million, has seen the devastating consequences of HIV and AIDS firsthand, reporting a prevalence rate of around 17.6% in 2008 (with rates for females and males 20.4% and 14.2%, respectively) (Department of HIV/AIDS Prevention and Care 2009). These devastating statistics rank Botswana as having the second highest HIV prevalence rate in the world, just under Swaziland (based on an estimate of the percentage of adults [aged 15-49] living with HIV and AIDS) (Central Intelligence Agency 2009). Without the presence of AIDS, Botswana's population had been projected to be 2.1 million by 2010 (Ntseane 2004).

Despite a wealth of resources and international support, Botswana's infection rate continues to have devastating effects. Dr. Peggy Gabo Ntseane of the University of Botswana finds that the most significant factors behind the spread of HIV and AIDS are gender inequalities, stigma, and denial, all of which are factors ignored by international awareness campaigns such as "Abstain, Be faithful to one sex partner and use a Condom" (ABC). ABC and other prevention strategies were often externally imposed on local communities. This resulted in subsequent alienation of the communities because of the "one size fits all" structure of ABC, which failed to sufficiently engage the behaviors and values of the communities themselves (Ntseane and Preece 2005). At this time of financial constraint, better resource mobilization and strategies to approach behavior change and treatment must be addressed while engaging participants within the context of the larger community and society.

1.2 The Study Problem

Engaging a multi-dimensional approach to the factors and causes leading to Botswana's high HIV prevalence rate, intervention methods can be analyzed and subsequently improved. By exploring alternative strategies that address the cultural implications of the disease, empowerment strategies can be focused at the culturally specific Batswana community rather than targeting individuals within a specific demographic. Only by bridging the gaps between local initiatives, realities, and the international aid community can positive behavioral change be attained.

1.3 Objectives of the Study

Broadly speaking, the research set out to assess donor-funded intervention strategies in the current efforts to fight against the spread of HIV and AIDS in Botswana. To do so the study focuses on the following objectives:

1. To contribute to the stock of existing academic literature on the effects of donor-driven campaigns in the fight against HIV and AIDS in Botswana.

2. To gain an understanding and appreciation of some of the complexities surrounding foreign aid policy and its relationship between local and international communities.

3. To address cultural and behavioral implications of HIV and AIDS.

4. To identify solutions that hold the potential to bridge the gap between local realities and donor needs.

1.4 Justification of the Study

As noted in the introduction, the AIDS epidemic continues to wreak havoc on many communities throughout Botswana. A thorough assessment is needed to curb its spread. This study is of significance for three major reasons:

1. The study provides a critique of donor-led HIV related initiatives in Botswana.

2. The study contributes to the stock of existing knowledge while adding to the limited research on community-oriented versus individually targeted

programs within Botswana.

3. Beyond the theoretical realm, this study raises awareness and increases appreciation of some of the complexities that impair bridging the gaps between traditional Batswana cultural values and donor needs.

1.5 Research Questions

1. Does discourse in donor funding and structure align with local realities?

2. Are program structures and funding effective, sustainable, and efficient?

    a. *Effectiveness*: Aligning to Botswana's National Strategic Framework (NSF) and criteria for reducing and eliminating new incidences of HIV and AIDS.

    b. *Sustainability*: Program structure and funding that does not lead to a dependence on foreign aid. Donor funding should promote local NGOs in the generation of their own self-sustaining funding.

    c. *Efficiency*: Maximizing the capacity and productivity of intervention programs with minimum wasted time and expense.

3. Do donor funding, structure, and support incorporate the whole community (rather than singling out target groups), and are they aligned with local values and tradition-based systems and customs?

1.6 Methodology

In order to obtain a holistic understanding and appreciation of these issues, research was conducted at one local organization, the Botswana Christian AIDS Intervention Program (BOCAIP), and multiple methods were employed. Data collection began with visits to the head office in Gaborone where informal observations and discussions took place amongst the Acting National Coordinator and the general staff. The study also incorporated individual discussion with each project officer in the head office and group discussions. Additionally, on-site observations and discussions were conducted with center coordinators and staff in Old Naledi (a local slum in Gaborone), Lobatse, and Phakalane (although the actual site was based in Kumakwane). This study began the 17th of February 2011 and ended the 5th of April 2011. BOCAIP provided data that spoke to the relevance and importance, or lack thereof, of foreign aid in the fight against HIV and AIDS in Botswana. Data collected through discussion and observation, within BOCAIP's field sites and headquarters, was scrutinized through ethnographic analysis.

1.7 Ethical Issues

When carrying out a study of human behavior, ethical issues can arise throughout the research period which must be addressed. At the centre of the study was a community of people entitled to full disclosure of research goals, methods and sponsorship. Of prime importance was the need to ensure that data collected would be utilized only for purposes specified and disclosed to the study subjects.

Second, for the duration of the study, every precaution was taken to ensure that all

participants took part in research activities voluntarily and with their informed consent. In line with the above, the study strived to protect the confidentiality of the persons involved while informing all participants of any limitations to the confidentiality.

Third, it was incumbent upon the researcher to ensure that the rights and dignity of all participants were respected and that no participant should suffer any harm, physical or otherwise, in consequence of his or her involvement in the research process. The researcher operated with honesty and integrity at all times.

Fourth, the study topic required discussion with socially and professionally prominent members of the community and, for this reason; care was taken to ensure that participants' views and opinions were addressed so as not to jeopardize the individual's standing in the larger society.

Fifth, participants were informed that feedback would be provided in a formal report. In this way, the research contributed to the existing pool of knowledge that would ultimately advance understanding of human behavior.

1.8 Limitations of the Study

Limitations existed in three key resources: time, funding, and people.

1. Time: The research was conducted over a period of just under two months. In effect, this was a limited amount of time to conduct field research and analysis as not all sites could be observed or staff consulted.

2. Funding: There was limited funding for the study. The sponsoring organization,

the Council on International Educational Exchange (CIEE), provided stipends to the local hosting organization and the UB academic supervisor as well as funding for housing during the research period in Botswana. However, no funding was provided for transportation and travelling.

3. People: The research required both researcher and participant input. The participants involved with this research were mostly women and thus biases could have occurred (as BOCAIP had very few men on staff). Since the researcher was not local and only had limited local knowledge of the Setswana language, limitations existed in that respect. Furthermore, the researcher was from the United States and thus not fully acculturated into traditional Batswana society. The final limitation was that the researcher was a young, white, middle-class, college student and thus perceived by some in a different social context.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

In part, this study examines the relationship between attitudes, behavior change, prevention, and treatment of HIV within the local community and the amount and utilization of donor funding. How is funding allocated and is it effective, efficient, and sustainable within the structural framework of local and international organizations and their programs? Does this lead to a dependence on donor support? What are the local realities and do western interventions address the specific cultural and community needs? In the following sections, the existing literature will be presented and gaps in the literature noted. Additionally, the literature will include the structure of many current initiatives as compared against the approaches presented in this paper.

2.2 Overview of Botswana

Figure 1

http://classroomclipart.com/clipart-view/Maps/Black_and_White_World_Maps/Botswana_map_34MBW_jpg.htm

Situated at the very center of southern Africa, Botswana is a country of great resources, wealth, and complexity. Bounded to the west by Namibia, to the north by the Caprivi Strip of Namibia, Zimbabwe, and Zambia, and to the east and south by South Africa, Botswana is an arid and semiarid country characterized by a dry continental climate. The Kalahari Desert, occupying two-thirds of the country to the west, contributes to this dry climate with annual rainfall ranging from 3.9 inches in the west to nearly 17.5 inches to the east. Rainfall is both meager and unreliable, and drought is a common feature for this climate. (Miller and Middleton 2007)

Botswana was minimally influenced by Western culture during the colonial era as it was assumed by the British to contain very few natural resources. In 1885, the British proclaimed Botswana a protectorate, having never been colonized, called Bechuanaland. It was not until December of 1960 that Britain approved a new constitution for Bechuanaland that an executive, legislative, and African council were established (BBC News 2011). In June 1964, Britain accepted proposals for a democratic self-government in Botswana, and the capital was moved from Mafikeng in South Africa to the newly established Gaborone ("History of Botswana" 2009). Botswana celebrated independence from Britain in September 1966, and Sir Seretse Khama, a key member of the independence movement and of the Bangwato tribe, was elected the country's first president ("History of Botswana" 2009). Currently, almost 50 years later, Sir Seretse Khama's son, Ian Khama, is the current president.

Botswana is sparsely populated (with a population of around 1.7 million people), largely in consequence of the limitations of its dry-land environment. Although

agriculture remains a critical source of livelihood for most Batswana, cattle production for export still contributed to about 70-80 percent of the Gross Domestic Product in 2003-2004 ("Beef Sector Background" 2007). Diamonds were discovered in the country shortly after reaching independence from Great Britain in 1966. Since independence, Botswana has had one of the world's fastest-growing economies with an average annual growth rate exceeding 10 percent at times (Miller and Middleton 2007). In 2010, Botswana had the second-fastest economic growth rate in the world with a rate of 14.4 percent (Nasser 2009). Because it is one of the world's largest producers of diamonds by value, Botswana now has emerged as a middle-income nation ("Botswana Profile" 2011) with admirable achievements in its economic growth, infrastructure development, education and healthcare (Mohohlo 2011).

The World Bank and other institutions consider Botswana and its economy, public-management system and liberal democratic political government a model of success. When Botswana achieved independence in 1966, it was one of Africa's poorest nations with few paved roads, schools or hospitals (Mohohlo 2011). Today, the country is blessed with mineral wealth, political stability, and social benefits for its citizens such as a national digital telephone network and free, country-wide education and healthcare, largely funded by the government (Mohohlo 2011).

In addition, one of Botswana's greatest sources of pride is its citation by Transparency International (TI) in 2010 as being the least corrupt country in Africa. It has also ranked as one of the least corrupt countries in the world for 15 years in a row (Office of the President 2010). Although Botswana is characterized by many as a story of success, HIV and AIDS have not spared its people; for a time HIV and AIDS infected

about 30 percent of the country's population (the second highest rate in the world).

All of these factors demonstrate that Botswana has enormous pride in its independence and in its political history of resistance to Western, colonial influences. The Batswana take pride in their national culture and uphold many traditional cultural values ingrained in their tribal histories. These attitudes affect all sectors of Tswana life including HIV prevention, behavior, and beliefs.

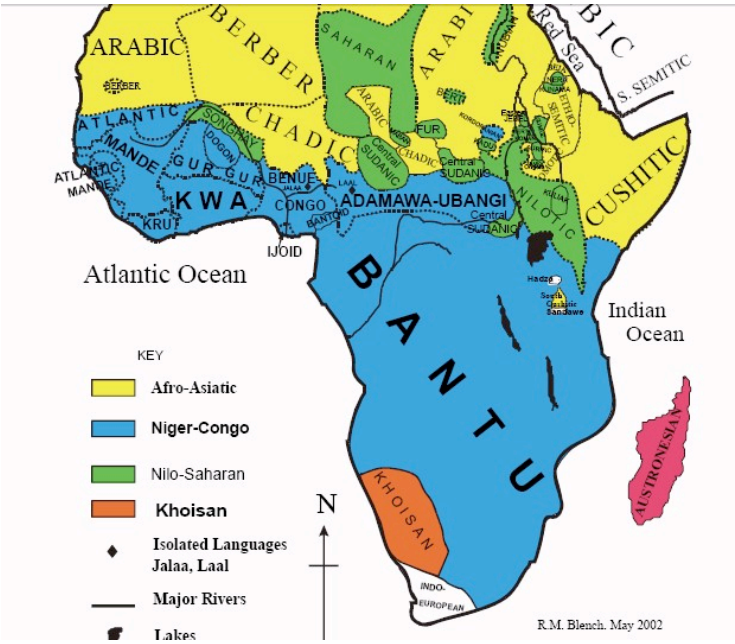
2.3 The Tswana Tribe in Botswana

Botswana is composed of both Bantu- and Khoesan-speaking groups. Bantu speakers include the Tswana; closely related Kgalagadi; and the Kalanga, Mbukushu, Herero, Mbanderu, and other groups (Miller and Middleton 2007). Khoesan speakers include members of the numerous San groups and a small number of Khokhoe (Miller and Middleton 2007). The Tswana (plural Batswana, sing. Motswana—the terms additionally are synonymous with citizens of Botswana themselves) are one of the three major divisions classified under the Sotho group of Bantu-speaking peoples of central southern Africa (Schapera 1953). Sotho is a group of closely related Bantu languages, including Tswana, Lesotho, and Pedi, spoken in southern Africa (The American Heritage Dictionary 2003). The Tswana are sometimes also termed "Western Sotho" (Schapera 1953).

The Tswana are by far the largest, most dominant population group (more than 1 million Tswana living in Botswana or 79 percent of the population) (Miller and Middleton 2007). They are divided into smaller, locally based political and totemic units. Totemic units refer to the clans' associations with animal, plant, or other natural objects

that serve as the tribal or traditional emblem and are sometimes revered as a clan's founder, ancestor or guardian (Totemic 2003). These units include the Ngwato, Twana, Kwena, Ngwaketse, Kgatla, Malete, Rolong, and Tlokwa in Botswana (Miller and Middleton 2007).

Figure 2



http://music000001.blogspot.com/2007_06_01_archive.html

Though nothing definite is known about the origins of the Tswana (as most of their history was based on oral knowledge passed down through the generations), it is conventionally believed that the Sotho peoples separated from the main body of Bantu-speaking peoples somewhere in the vicinity of the Great Lakes of the Rift Valley in East Africa around 1600 AD (Miller and Middleton 2007).

They entered southern Africa (mainly Botswana, the western Transvaal, and northeastern Cape Province) in three great migrations. The first migration is evidenced

today by the residing people known as the Kgalagadi who settled in the eastern part of Botswana. Following the Kgalagadi came the ancestors of the modern Rolong and Tlhaping peoples who settled around the upper reaches of the Molopo River from which they slowly spread south and westward. The third and greatest migration brought the ancestors of all other Sotho tribes to the southwestern portions of the Transvaal region. This group soon divided into the separate groups of the Hurutshe, Kwena, and Kgatla. (Schapera 1952)

Although there is some variation in dialect and culture, overall the Tswana are culturally "homogenous," and are the dominating ethnic group in Botswana. Thus, for the purpose of this study, research was focused on the Tswana majority. Tswana political units are traditionally based on a putative kinship principle that serves to divide the society into discrete groups. Most of these groups constitute chiefdoms composed of a single ruler or chief, his council, and his kin. In modern times, however, the concept and distinctions of chiefdom are based more and more on "memory culture." (Alverson 1978)

Traditionally, Tswana are a self-sufficient agricultural and pastoral people. Water has always been the single most important variable in determining scope, scale, and mix of various food-preparation strategies. Agriculture throughout most of western Botswana is confined to animal husbandry and kitchen gardens where groundwater is available. The Tswana value animal husbandry and arable agriculture equally. Additionally, animals are central to one's worth, self-esteem, and peace of mind. (Alverson 1978)

Typically, each Motswana has three residences, although only one is the "official" home. The Motswana lives, first, in the home village (nucleated settlements composed of

territorial groups of kin by descent and marriage). At the agricultural land, the Motswana maintains a second residence (lived in during the rainy season when plowing, planting, and harvesting are taking place). Cattle are kept at the third location, or the "cattle post," where accommodations are rudimentary in areas of rich grassland and water supply. (Alverson 1978)

Tswana society puts great emphasis on kinship as the basis upon which the political, judicial, economic, and religious aspects of society are organized. Sex, age, and lineage association are the most important principles in recruitment to social roles. In terms of wealth, generally, the less "complex" the society is and the less "social-economic surplus" produced, the smaller the gap in wealth disparity. According to Hoyt Alverson in his book, Mind in the Heart of Darkness, the Tswana are an egalitarian society. However, from the point of view of the Tswana themselves, their society exhibits enormous differences in wealth. Traditionally, cattle, seen as a source of draft power, cash, advantageous loans and alliances, clientele favors, and women, define wealth to the Tswana. These differences in wealth, however, are traditionally subject to redistribution, similar to many agro-pastoralist groups in eastern Africa as well. In former times, wealth carried a burden of generosity. This communal life was seen to be antithetical to the individualist freedom to accumulate, hoard, and control scarce resources against the interests of the community, as was seen with the advent of Europeans and their governments. (Alverson 1978)

Throughout the study period, it was observed that the distribution of wealth, in regards to cash, material goods, resources, favors or services, amongst the peoples in Gaborone was always in constant movement, travelling from person to person. It was this

system of ever-present loans and debts that was fundamental to the structure, strength, and livelihood of the community itself. Through this redistribution of wealth, trust and bonds were often fostered and a cohesive interlinked community emerged. This can be translated to HIV-related programs, as it is impossible to affect the individual without affecting the community.

In the U.S., often the individual goal is to reduce debt in order to be independent of owing or being owed by others. However, in Botswana, lending money, resources and services is the basis of community and family ties. Everyone conducts business with everyone else through an informal system of borrowing and lending. Dependence on others is the basis of community. This dependence and debt structure is welcomed and acts as a catalyst for socialization, thus strengthening community bonds through trust, reliance, and aid when needed.

Because of this constant give and take atmosphere, HIV and AIDS resources that target specific individual demographics privatizes individual needs and thus interrupts the egalitarian nature of Botswana community. This singling out of certain individuals often leads to stigmatization and discrimination, stratifying the community and creating an unequal balance of power. When organizations ignore the natural egalitarian structure of the Botswana community, they create conflict between stratified individuals and the rest of the community and distract from the message being pressed. Rather than focusing on health and safety, individuals will first focus on issues relating to community values. The first priority in Botswana culture is the community itself (based on familial kinship ties and trust), the state of individual health and safety many times comes second. Organizations must tailor programs to fit within the structure of society so as to create a

cohesive network of individuals working towards a common goal.

2.4 HIV and AIDS in Botswana

It was in 1987 that Botswana began its initial response to HIV and AIDS following the first recorded AIDS case in the country two years earlier. Ten years later, a broader national response to the epidemic was implemented and was based on a multi-sectored, participatory approach. For many years, the prevention strategy in Botswana was a centrally managed, largely externally funded "Abstain, Be faithful to one sex partner and use a Condom" (ABC) program, mentioned in the introductory remarks. This Western attempt to redress the escalating spread of the HIV virus focused on increasing awareness in terms of the symptoms, modes of transmission, and means to prevent infection (Ntseane 2004[2]). Botswana, in 2004, had one of the world's largest HIV and AIDS awareness rates at 78-90 percent (Ntseane 2004[2]). However, local research conducted at the University of Botswana finds that awareness does not translate into prevention or behavior change (Ntseane 2004[2]). As demonstrated by the research, programs must also focus on approaches extending beyond awareness alone.

The National AIDS Coordinating Agency (NACA) was established on December 14, 1999 under the Botswana Ministry of Health (NACA [1]). Later, NACA was reorganized under the Ministry of the State President. It has since served as the secretariat to the National AIDS Council. The creation of NACA was based on the realization that HIV and AIDS were not only the most important public health challenges facing the country, but also posed the most serious challenges to Botswana's future socio-economic development (National AIDS Coordinating Agency Background). Since HIV and AIDS

were declared a national emergency in 2003, the National Strategic Framework (NSF) has been the government's response to this emergency. NSF is NACA's key platform for implementation of the National Response. NACA's main objectives have been to:

- "Provide strategic direction and set key priorities in the quest for lasting solutions against the epidemic."
- "Develop and support programs and policies that can deliver on identified priorities."
- "Develop infrastructure, tools and mechanisms used for monitoring and evaluation of progress of the National Response," (National AIDS Coordinating Agency *HIV Prevention*).

The Government of Botswana has made the commitment to achieving the goal of "Zero New Infections by 2016" as described in Vision 2016. This National Operational Plan is set within the broader context of the National Strategic Framework to reach this goal. At the core of this plan is a vision to scale up HIV prevention in Botswana, going past the dimensions of awareness, in order to establish an aggressive prevention implementation program that fills in the gaps in current programming. According to the NACA, "Botswana is committed to implementing the prevention programme through strategic communication and related community intervention in the following basic categories:

- The national strategic communication harmonizing and support functions. A number of centralized functions including branding, materials development,

national harmonization and collaboration, clearinghouse operations, training and capacity-building, research and evaluation help to ensure consistency, quality and economies of scale.

- Strategic Communication to Prevent Sexual Transmission. The approach focuses on addressing the key determinants of sexual transmission to increase the use of primary prevention behaviors, and increasing 'Prevention with Positives.'
- Communication Support to HIV and AIDS Services components of the Minimum Package to increase demand for and improve client education and client use of HIV Counseling and Testing (HCT), Prevention of Mother to Child Transmission (PMTCT), Sexually Transmitted Disease (STD), and Blood Borne Transmission. Also, it enhances interaction between service delivery sites and the communities they serve.
- Community mobilization is a participatory process that increases a community's sense of ownership and collective efficacy. It is a transformative process, shifting a community from 'recipients"' or 'beneficiaries' of 'projects' to active planners and participants in the health and well being of the community and its members." (NACA [2])

These objectives are aligned with this study's main goals in increasing community participation and integration in addition to improving efficiency and effectiveness through better communication between partners and participants. There are gaps, however, within the categories of the Vision 2016 Plan as the role of donor aid partners is not incorporated nor a means to more sustainable programs.

2.5 The Politics Behind Development and Aid

With pressure on international aid budgets increasing (along with other factors such as climate change and rapid population growth adding new financing demands) and aid to Botswana decreasing, it has become more imperative to improve current aid strategies and streamline available resources. Often streamlining these HIV-related programs means initially testing the relationship between funding and practice followed by successful implementation.

With his 2004 publication of "Condom Social Marketing, Pentecostalism, and Structural Adjustment in Mozambique: A Clash in AIDS Prevention Messages," James Pfeiffer, with the Department of Anthropology at the Case Western Reserve University in Cleveland, conducted nearly four years of fieldwork with a U.S.-based public health Non-governmental Organization (NGO) in central Mozambique. These periods included 1993-95, 1998, five weeks in 2000, three months in 2002, and five weeks in 2003. He worked closely with the Mozambique Ministry of Health and with Population Services International (PSI) to critique social marketing techniques in the context of HIV and AIDS in Africa. Pfeiffer argued that over the past 20 years, "social marketing" has emerged as the dominant approach to health education and communication in the developing world, often replacing community empowerment, outreach, and participation programs. This concept of social marketing (SM) centers upon the use of commercial advertising techniques and private-sector distribution of health products to promote "individual behavior change." (Pfeiffer 2004)

The "behavioral change hypothesis" has been the prevailing public health

orthodoxy in explaining an individual's vulnerability to HIV and AIDS. It is premised on the approach that there are certain "risk groups of individuals," who make rational choices based upon information presented to them on health risks. This approach recognizes the relationship between development issues, societal factors, and the HIV and AIDS epidemic. The majority of bilateral funding is still rooted in a view of the individual requiring a change of behavior. Thus current strategies for HIV and AIDS are premised around the belief that HIV and AIDS are "a communicable disease driven by the behavior of individuals" rather than incorporation of the community for which there must be interventions to change individual "risky behavior." The Norwegian Agency for Development Cooperation (NORAD) and the Department for International Development (DFID) classify interventions to prevent sexual transmission such as condoms, combinations of strategies to deliver condoms, behavior change programs, voluntary counseling and testing, and improved diagnostics and management of other STDs. (Jones 2004)

According to Pfeiffer, although, SM has become a centerpiece of AIDS education and prevention in many sub-Saharan African countries, its implementation has not been driven by a thoroughly demonstrated efficacy in improving health by motivating behavior change. Critics charge that the SM distracted from structural determinants and constraints on health-related behavior in addition to excluding genuine community participation in tackling problems in public health. In addition, SM stresses commercial advertising techniques, thus contrasting with the "Health-for-All" primary health care (PHC) ideas proposed at the International Conference on Primary Health Care in 1978. Regardless, SM has been widely embraced, especially in Africa, by international nongovernmental

organizations (NGOs) and ministries of health, and can be traced to the promotion of privatization and free-market economies in the era of structural adjustment policy across the region. (Pfeiffer 2004)

Structural Adjustment Policies (SAPs) are formulated as loan conditions by Northern governments and International Financial Institutions (IFIs) mandating macroeconomic policy changes and obligating recipient nations to liberalize their trade and investment policies. Through these policy agreements, Northern governments have worked to restructure the economic policies of these recipient nations. The U.S., in particular, plays a fundamental role in the designing and financing of SAPs (mainly with the World Bank and International Monetary Fund [IMF]) and since the 1980s has been routinely conditioning its aid agreements on acceptance of a package of economic reforms and adherence to the prescriptions of the World Bank and IMF. They are furthermore insistent on changes in the recipient nations' economic policies to facilitate increased U.S. trade and investment. These changes generally entail severe reductions in the recipient government's spending and employment, higher interest rates, currency devaluation, sale of government enterprises, lower real wages, reduced tariffs, and liberalization of foreign investment regulations. Overall, SAPs share a common goal to move countries away from self-directed models of national development that focus on the domestic market towards models that stress complete integration into dominant global structures of finance, trade, and production. (Oringer and Welch 1998)

In order to receive grants and loans for programs such as those relating to HIV, developing countries are expected to adopt SAPs, often set in such a framework in which the needs of the individual community are ignored and social services out of reach. There

is an ongoing debate whether recipient governments really benefit from foreign aid and whether recipient governments should fund social services on their own. (Youde 2010)

In the last two decades, recipient nations have seen the gradual rollback in public-sector PHC services led by SAPs that have reduced spending for government services and privatized local economies. This rollback in public services has coincided with the intensified AIDS crisis, and the factors which fuel the AIDS epidemic also are the factors that seem to come into play in SAPs. (Pfeiffer 2004)

According to Pfeiffer, "Social marketing, and its Western NGO and donor proponents, arrived with a prepackaged approach to AIDS prevention that could be easily integrated into ongoing economic reform programs that emphasized 'cost-effectiveness' as the bottom line for priority setting in health" (Pfeiffer 2004). SM does not adjust or sensitize its structure to meet community needs and dynamics. It attempts to change behaviors like sexuality without inclusion of genuine community dialogue, participation, and monitoring and is not only ineffective, but may actually be harmful (Pfeiffer 2004).

Although SM and SAPs have been severely criticized for their one-size-fits-all structure and negative consequences to the receiving nation respectively, many developing countries are already immersed in these wide scale, global structures. Thus, the following literature will focus on the enhancement of funding within these frameworks in terms of effectiveness, sustainability, and efficiency.

Often, there is a tendency among donor funding to concentrate on prevention programs rooted in Western science, while underplaying or ignoring complex social dynamics specific to the targeted area. This leads to a regress to traditional behaviors

because practices cannot be fully implemented into society. (Jones 2004)

Another issue roots itself in donor bias toward prevention, and the fact that donors place an opportunity cost upon treatment without ever performing a "cost benefit" analysis of prevention programs. This is to say that donors do not plan the dispersal of resources effectively or efficiently enough to reach the highest benefit capacity. They urgently need to assess where and how prevention and treatment are being combined successfully. Stigma and unequal power relations exclude many people from participating equally in the economic, social, and political dimensions of society. (Jones 2004)

In terms of funding within these structures, "absorptive capacity" refers to the ability to deal effectively with sudden influxes of capital. In the current HIV and AIDS context, absorptive capacity also refers to the capacity of organizations and sectors to use the influx of funds in a way that has a substantial effect on the epidemic and on people's lives. One major issue facing current campaigns is that scaling up HIV and AIDS interventions quickly may lead to locally rooted action being replaced with less effective action on a wider and externally imposed basis. This perception aligns itself with one of this study's aims to analyze western-based intervention strategies and the level of community awareness and incorporation into these plans. In addition, the reality of funding and spending is that it is often variable, with sudden influxes or delays. Ongoing provision of and investment in relevant technical support is crucial in increasing capacity and effectiveness of community-based organizations, as this would expedite these processes. (Halmshaw and Hawkins 2004)

In addition, there needs to be more focus on "disbursement capacity." This refers to the ability of governments and international donors to disburse funds to all sectors (rather than a few highly affected, isolated areas) so as to have a significant and wide effect on the epidemic and on people's lives. According to Youde (2010) however, "…states with higher HIV prevalence rates would receive more money from external sources. However, donor states do not always distribute proportionately with the recipient's needs." Donors tend to concentrate either on a small number of sites with piloted, "demonstration projects," or attempt to support the significant and broad scaling up of impact while pursuing a combination of routes (usually based on wide scale, pre-structured programs) (Halmshaw and Hawkins 2004). These routes attempt to increase field support capacity through the incorporation of government intermediaries (Halmshaw and Hawkins 2004). These middlemen are expected to support community-based implementers and NGO providers (Halmshaw and Hawkins 2004). However, these methods often fail as they are not properly employed or fully executed. Many of these idealized goals are left unfulfilled.

Overall, these factors have demonstrated the need for HIV and AIDS prevention projects based on culturally specific education principles that stimulate people to seek solutions within their own diverse cultural contexts (Ntseane and Preece 2005). Educational messages that simply tell people to "use a condom" do not address the power balance between males and females or other cultural and community based needs (Langen 2005) as issues such as gender violence, stigma, and discrimination are still prevalent.

Ideally, this study's research is meant to support an HIV and AIDS project in the

future that bridges the gap between Western approaches and Batswana culturally specific approaches. It is aimed specifically at addressing the values, tradition-based systems, and customs associated with the local community. By addressing these cultural components and engaging in participatory approaches that focus on collaboration between people in their own communities, Botswana will likely see a future without AIDS. (Ntseane and Preece 2005)

Strategies such as the Human Science Research Council's goal "to explore the opinions of the Batswana about the HIV prevention strategies with a view to assisting the government of Botswana in developing appropriate prevention strategies to reduce the spread of HIV" need to be further employed (Tabane and Delport 2009). There should be a similarly structured study within Gaborone engaging the people themselves in their practices, customs, and beliefs surrounding HIV. This would allow Batswana to embrace their culture through practices such as circumcision within the traditional schools, sexual education by the parents, and further relate religious beliefs and Christianity in order to adopt sexually healthy behavior (Tabane and Delport 2009).

2.6 Conclusion

From the literature reviewed, analysis has been conducted on some of the overarching issues surrounding HIV and AIDS in relation to foreign aid policy and cultural realities in Botswana. Gaps in the literature have been identified as there currently is little research directly examining community responses to HIV behavior change campaigns and treatment in Botswana. The following chapters further explore these questions and topics.

CHAPTER 3

RESEARCH METHODS

3.1 Introduction

This chapter introduces data collected over a period of seven weeks. The purpose of the study was to present and analyze the structure of the Botswana Christian AIDS Intervention Program (BOCAIP) in terms of program effectiveness, sustainability, efficiency, donor funding, and foreign aid policy. All discussions and observations were based around the following themes:

- To overview the type, structure, and purpose of programs run by BOCAIP.
- To identify who formulates, funds, and influences these programs.
- To critically address the structure of each program and the mission objectives of BOCAIP in relation to funding.

Overall, the above themes were meant to assist in assessing the total level of effectiveness of BOCAIP's campaigns (during the study period) against the spread of HIV and AIDS in Botswana. Throughout the study, emphasis was placed on qualitative observation and open discussion. The questions asked were intended to shed light on the realities behind current campaigns and possible limitations or improvements that could be made in the future to improve effectiveness. Questions asked varied from one discussion to another; however, a similar question guide (see Appendix) was used. Some discussions were particularly enlightening (in terms of addressing objectives and the research

questions), and thus proved more relevant to the study than others.

3.2 Respondents

In total, fourteen respondents were questioned, including the Acting National Coordinator, project officers, counselors, partners, and center coordinators.

Table 1

Project Officers	4
Counselors	5
Center Coordinators	2
Partners	1
Other	2
Total	**14**

The respondents were all female except for one male partner and one male center coordinator employed under BOCAIP. Because of limitations (such as time constraints and funding), most research was conducted within the Gaborone Head Office, although three sites were also visited and analyzed. These sites included Old Naledi, Lobatse, and Kumakwane (although the interview was conducted in Phakalane).

3.3 Overview

The Botswana Christian AIDS Intervention Program (BOCAIP) was founded in

1996 in response to a national call to adopt a multi-sectored approach in curbing the spread of HIV and AIDS. BOCAIP is a national network of both church and para-church organizations involved in HIV and AIDS interventions in Botswana. The program began by adopting an approach rooted in Christian principles and values. This approach was agreed upon and shared by numerous churches, communities, para-church organizations, and the Botswana government. BOCAIP is located across the country in eleven centers (Maun, Molepolole [with satellites in Kumakwane and Thamaga], Kanye, Serowe, Selebi-Phikwe, Tsabong, Masunga, Francistown, Ramotswa [with catchments in Mogobane, Otse, and Tlokweng), Gaborone, and Lobatse]. BOCAIP carries out activities and interventions including, but not limited to, community mobilization, community-based initiatives, counseling, education, youth work, support groups, orphan day care, emergency material assistance, and income-generating projects.

3.4 Themes

Theme One: Program Overview

Currently there are eleven counseling centers across the country that work in the following areas:

- HIV Counseling and Testing Services (HCT).
- HIV and AIDS prevention (i.e., Multiple Concurrent Partners [MCP]—five districts).
- Community Tuberculosis (TB) Care—five centers nationally.

- Care of Orphans and Vulnerable Children (OVC) in Selebi-Phikwe, Maun, and Molepolole (satellite in Kumakwane).
- HIV and AIDS Counselor Training and other training.
- Peer Mother Project- Prevention of Mother-to-Child Transmission of HIV (PMTCT)—57 sites including, but not limited to, Maun, Ramotswa, Selebi-Phikwe, Tsabong, and Lobatse.
- People Living with HIV and AIDS (PLWHA) support groups.
- Be Faithful HIV Prevention Program- Promotes faithfulness among married, cohabiting, and courting couples—in Kanye and Serowe.

There are also a number of youth projects and activities:

- Youth income generation activities in Selebi-Phikwe.
- Behavior change through abstinence and being faithful to one partner teaching strategies in four centers of Molepolole, Kanye, Masunga, and Tsabong.
- Youth Blood Safety project in Ramotswa, which encourages youth to remain HIV negative through a pledge to donate blood 25 times in a lifetime (not currently in operation).
- Basha Lesedi (Youth are the Light)- Youth project on abstinence and parent child communication in Masunga and Good Hope.

Two programs, the Basha Lesedi Project and Be Faithful, were particularly

innovative and of interest to the study, especially in terms of a successful representative model and will be referenced in the Conclusions and Recommendations section. They are described below:

The Basha Lesedi Project was a five-year program beginning in 2006 and ending March 31, 2011. Funded by Family Health International (FHI), Basha Lesedi was a multi-partnership program between BOCAIP and other NGOS—Humana People to People (HPP)—household visits, Botswana Network of People Living with HIV/AIDS (BONEPWA)—activities with individuals affected and infected by HIV and AIDS, Botswana Network of AIDS Service Organizations (BONASO)—coordination, and Makgabaneng—media. Each partner addressed different aspects surrounding HIV and AIDS, including People Living with HIV and AIDS support, interpersonal communication, and dramas. The main objectives of the project were to reduce infection, target youth ages 10-17, and empower youth with skills and knowledge to induce behavior change. Beneficiaries of the project included youth, parents, pastors, and key players in the community. BOCAIP, whose role was to coordinate activities with faith-based organizations, specifically worked in the church with these beneficiaries to empower members through the incorporation of HIV prevention in sermons. (Basha Lesedi, 2011)

The Christian Family Life Manual was used to teach the beneficiaries. It covered topics such as building healthy relationships, abstinence, and good decision-making. The Ministry of Health selected key partners, and the manual was translated and made specific to Batswana culture. Both locations for the project were based on current statistics recorded before project initiation. As HIV prevalence rates were known to be

higher closer to borders, both locations were good candidates as they were very near to South Africa or Zimbabwe. The Basha Lesedi Project was the first of its kind to target the age group of youths from 10-17. Despite an initial confusion by the population as to which partner was doing what, the program received positive feedback to the point where participants were suggesting (that if funds were available) the program should be expanded to other villages and locations. Monthly meetings as well as annual and quarterly meetings, forums, and reports were conducted to consider cultural context issues and the effectiveness of the program. By doing so, these meetings offered a platform for suggested changes or improvements based on the given demographics, objectives, goals, and budget. Overall, the program was well structured and successful in the following ways. The project aimed to change social norms, built skills among young people to help them avoid alcohol and peer pressure, increased the ability of guardians, parents, and community leaders to support health choices, and increased the capacity of local organizations to engage in participatory project planning and implementation (FHI 2011).

The "Be Faithful" HIV Prevention Program was funded by United States Agency for International Development (USAID) through the Academy of Educational Development (AED). It incorporated community outreach, promoting faithfulness among married, cohabiting, and courting couples. In addition, the program spread education and community incorporation through raising awareness of MCP, gender-based violence, the risks of alcohol abuse, delayed sexual debut, and cross-generational sex. Be Faithful was implemented in the villages of Kanye and Serowe between 2008 and 2011. The program was based on the collaboration between different sectors (similar to Basha Lesedi) such

as field officers, pastors, and married couples. Field officers addressed issues such as MCP, pastors were in charge of the Be Faithful components—talking to married couples and incorporating relationship assessment and enrichment, and married couples conversed with other married couples, using a Marriage Enrichment Guide, about the risks of HIV. Stakeholder forums were held quarterly and allowed for the input of key stakeholders and beneficiaries, in addition to a yearly process assessment. Initially, the programs had issues with the community opening up to the young field officers, but as time went on the beneficiaries accepted the program. According to BOCAIP, the program was a success as it reached almost all couples throughout the community, partnerships within the initiative were strong, and the program established key links between marriage partners. In 2010, one couple cohabitating for 20 years was successfully persuaded by a Be Faithful trained pastor to get married. Others praised the Be Faithful program for its success in resolving marital conflicts and strengthening bonds between partners.

Theme Two: Donor Funding

Overview:

Following its inception in 1996, for three years BOCAIP relied on part-time volunteers as the NGO received little and sometimes no funding for paid staff. Nonetheless, services were delivered with the minimal resources acquired from local churches. The first donor funding was received in 1997 from the Swedish International Development Agency (SIDA) for training and community mobilization. Bristol-Myers was the next to donate in 1999 with a commitment to support BOCAIP for three years, undertaking orphan care work and counseling. As BOCAIP gained reputation, with

donors such as Africa Comprehensive HIV/AIDS Partnership (ACHAP), Norwegian Church Aid, SIDA, United Nations International Children's Education Fund (UNICEF), The Bill and Melinda Gates Foundation, Canadian International Development Agency (CIDA), the government of Botswana, and the Self-Help Fund of the US Ambassador of Botswana began to contribute major donations, expanding and increasing campaigns to meet the needs of the communities.

All programs run by BOCAIP were donor driven. Because of the exclusive reliance and compliance with donor objectives (as long as they are in line with BOCAIP's objectives), programs lasted only as long as there was substantial funding. The Botswana National Government funded a few projects dependent on the needs the government felt were most crucial for the population. Government funding was aligned with the National Strategic Framework (NSF) to guide national response. For example, at the time of study, the National AIDS Coordinating Agency (NACA) donated to BOCAIP programs such as MCP in five districts and HCT in eleven centers. However, depending on the program, there was often not enough funding to sufficiently carry out planned activities that fit the desired objectives. For instance, HCT continually faced a major challenge with retention of staff. Often this program faced a major shortage of funding and thus training, monitoring and evaluation, transportation, and salaries were often in jeopardy (donors only provided for a portion of each staff member's salary). Furthermore, job security was at stake, as programs at times would stop for up to six months due to gaps in funding. In Lobatse, for example, NACA funding was so limited that it could only cover the costs of stationary and a minimal fuel allowance (BWP250 or USD34 per month). BOCAIP struggled to reach the new national testing objective of five

patients per day because of difficulties in funding for community outreach, making phone calls for follow-ups, etc. In consequence to funding shortages and other challenges, the Lobatse HCT center did not have the capacity to recommend even one HIV positive patient to receive follow-up counseling and care.

Other programs not funded by the government but rather by foreign donors include projects such as the Prevention of Mother to Child Transmission project (PMTCT) (funded by the Botswana-United States Partnership [BOTUSA], the Center for Disease Control [CDC], and AED), Community TB Care (initiated by the Ministry of Health and funded by the Global Fund), Basha Lesedi (funded by FHI), Be Faithful (funded by USAID), OVC (funded by UNICEF and Project Concern International [PCI]), and PLWHA (funded by PCI) (Basha Lesedi 2011). Because of differences in foreign funding policy, programs ranged in structure and format, depending on donor needs. However, BOCAIP continually stood by its mandate and firmly believed in donor alignment with BOCAIP objectives.

Theme Three: Program Structure

Overview:

BOCAIP was composed of multiple church denominations across the country under its supreme governing body, the General Assembly. Elected by the General Assembly, a national management committee oversaw the work of the national office, coordinating the eleven centers across the country. In each center, there were locally elected management committees represented by the local church denominations in the area. This local ownership was vital to facilitating efficiency and acceptance by the community. The

local committees and the Center administration structured programs together, working to plan, implement, and monitor programs at the grass root level, thus ensuring ownership and sustainability. The Gaborone National Office coordinated and supported the centers, assisting in resource mobilization for all projects involving BOCAIP. BOCAIP had staff engaged in the following activities:

- Resource mobilization
- Financial management
- Program planning and management
- Personnel management
- Monitoring and evaluation
- Training
- Research and material development
- General administration
- Technical support to centers

In addition, each center had its own center coordinator, overseeing and coordinating administrative and program implementation activities for the Center.

Goal:

"To contribute to the prevention of HIV transmission and behavior change. To mitigate

the psychosocial impact of HIV/AIDS on individuals and the community."

Aim:

"The aim of the organization is to contribute to Botswana's National AIDS Strategic Framework's goal by using an acceptable Christian approach."

Mission Statement:

"The primary mission of BOCAIP is to demonstrate a Christian response to the HIV/AIDS pandemic by:

- Promoting behavior change that leads to life as God intended
- Empowering families to experience spiritual, emotional, relational and physical health
- Providing Christ-like care and support to those affected and infected by HIV/AIDS"

Objectives:

- Prevention of HIV/AIDS transmission through behavior change
- Mitigation of the psychological impact of HIV/AIDS on the individual and the community
- Strengthening of the national capacity to respond to HIV/AIDS

BOCAIP is an NGO falling under the National Response, a multi-sectored approach

involving Civil Service Organizations (CSOs), NGOs, Public Service Organizations, Business Coalitions, and Parastatals (a wholly or partly government owned organization), all with the main objective to mainstream HIV and AIDS response. Each organization must report to the National AIDS Coordinating Agency (NACA), establishing wellness programs and partnering with Civil Service Organizations and the Health Sector to do HIV work.

Donors often determined the framework of each program; however, at times BOCAIP was given mobility to run the directives themselves depending on the program. For example, BOCAIP submitted a proposal to the government to fund its self-directed TB program, thus giving more access to treatment within the structure of the National Strategic Framework. BOCAIP and its donors also often engaged in both baseline and post surveys. BOCAIP then would submit quarterly reports and organizational assessments that were conducted to identify program strengths and weaknesses.

3.5 Conclusion

The data collected over the listed weeks was compiled and themes were assessed and discussed with BOCAIP participants. Many individuals played critical roles in data assemblage during the data collection period through the use of extensive discussions both on and off-site. The themes sought to emphasize the role and structure of donor funded intervention strategies within the organizational framework of BOCAIP itself. The next chapter emphasizes and analyzes the existing data.

CHAPTER 4

RESEARCH RESULTS

4.1 Introduction

Compiled in this chapter is a comprehensive analysis of data accumulated from the compiled research. The research questions are addressed and final results are analyzed and discussed. These questions are compared against research collected in the field, and an analysis is subsequently conducted. Study objectives are also referenced and scrutinized.

4.2 Analysis

Using the research findings and the literature reviewed, content analysis was employed as a means of synthesizing the given data presented in chapter three. Through the utilization of ethnographic interpretation collected from discussions, site trips, and general observations, overall themes arose and general objectives were met. Discussions were based on the guiding themes and objectives defined by the study.

Overall, from the data collected and as referenced in the background and literature review, there has been evidence of both positive and negative program results (dependant on the specific program and criteria analyzed) and an overall decrease in new HIV incidences over the past decade. These results align with the National Strategic Framework and country-wide goals. BOCAIP, thus, provides effective programs across the board. Furthermore, results showed an adequate spanning of NGO outreach to communities. These programs together covered much of the country and successfully

provided program access and awareness of HIV prevention and treatment. This aligns with Ntseane's 2004 assertion that the country is already well-equipt with awareness of HIV (Ntseane 2004[2]). BOCAIP and other NGOS were seen penetrating areas such as shabeens, which are unlicensed drinking establishments, schools, clinics, workplaces, and events with an overwhelmingly positive community response for programs such as Basha Lesedi and Be Faithful. The structure of these programs were aligned with local realities, but the same cannot be said for other programs such as HCT and PMTCT. Outreach within churches has had mixed results for BOCAIP dependent on the area. In some areas the relationship between the NGO and churches was strong and willing whereas in other areas churches were hesitant to encourage HIV awareness and behavior change within sermons, etc.

Testing and ARV treatment have been at the forefront of the Botswana government's HIV prevention and treatment initiative and have been pervasively resourced throughout the country. Women within these programs showed increasingly positive attitudes toward status disclosure and openness compared to men who showed a higher resistance to new methods. Women utilized existing resources aiding in behavior change by way of counseling, testing, and treatment. These positive results again proved that, more often, when local realities were addressed, programs could have a higher fecundity for success. This difference in attitude between females and males perhaps connects with the power imbalance seen between the two in terms of awareness (Langen in 2005).

In terms of BOCAIP's affiliation with donors, BOCAIP had firmly grounded itself in adherence to its mandate and would not accept funding unless proposed projects

were aligned within the objectives of the NGO. At times, BOCAIP was given the authority to devise its own project frameworks given that the project was consistent with the donor's specified framework. Generally, donors were consistent in conducting follow-ups, consultations, capacity analysis, and organization assessment. For certain programs, donors endeavored to fit their programs within the context of Batswana culture, and feedback was provided with annual reports, meetings, and surveys. Because of underfunding, however, the reports were often submitted with many inaccuracies. During these instances of donor interest in community tailoring, funding and structure did incorporate the whole community and aligned with local values and tradition-based systems and customs.

Because of reduced funding on a global scale as cited by UNAIDS 2010, another issue arose as many donors, such as the Global Health Fund, reduced or terminated aid within Botswana. This was also due in part to the perception among donors that Botswana is a wealthy nation, already well equipped with internal HIV-directed funding. However, despite this perception and according to BOCAIP staff, government funding is insufficient with local organizations still severely under-funded, overworked, and understaffed. This was apparent as many programs had major issues with retention of staff (because of the reduced funding—arriving late and available only for limited periods of time). This aligns with Halmshaw and Hawkins 2004 report that funding and spending is often variable, with sudden influxes or delays. These limited periods of aid left gaps in funding and thus challenges to job security. Unlike in the past, donors only accounted for a portion of staff salary, as there was an assumption that other aid was coming in to supplement the salaries. Because of these challenges, it was often difficult for BOCAIP

to hire new staff, as training was time-consuming and expensive. In addition to difficulties in retention of paid staff, BOCAIP struggled with its volunteer resources as many were often too old, uneducated, and in need of stipends to survive. These difficulties in funding and staff retention did not allow for maximum capacity and productivity of intervention programs. Thus, many programs were not efficient.

Despite a multitude of NGOs in Botswana, aid was subsequently spread thin. Cities and villages with high incidence rates such as Gaborone, Francistown, Masunga, Molepolole, and Good Hope had seen this influx of NGOs, but the rates of disease incidence were stagnant. This was due in part to an overload of similar or overlapping programs (due in part to a lack in NGO coordination by NACA and between the organizations themselves) and too much outreach to the point where it was left to deaf ears. Congested with too much support, people began to fall through the cracks. This again resulted in funding and program inefficiencies. This very rapid scaling-up of campaigns led to issues where locally-rooted action was replaced by less effective wide-scale initiatives; this occurrence is categorized as "disbursement capacity" (Halmshaw and Hawkins 2004). Whereas highly rated areas were overfunded (with overrepresented programs), other areas with low infection rates were severely underfunded. In 2010, Youde noted that donors do not always distribute funding proportionally, but rather focus on a few highly affected, isolated areas—ignoring the needs of other sectors. Many people did not attend follow-up counseling, and as seen in Lobatse alone, in some areas there were no follow-ups at all. Social support and home visits were also rare in underfunded areas such as Lobatse as there was not enough funding for transport or drivers.

Within programs such as HCT, there were no means to track clients or hold them accountable. Many people did not adhere to follow-up counseling or support programs provided. In the PMTCT program, for example, mothers often attended so many programs funded by different NGOs in the area that the intended message was lost and mixed feedings occurred. Mixed feeding refers to the mixing of formula and breast milk. By not sticking to either breast milk or formula alone, the risk of HIV transmission from mother to child greatly increased. These issues are aligned with the issue of communication between lay staff and the medical community. Often communication was disconnected, erratic, and at times clinics were seen by lay staff to be inflexible with their patients and providers (resulting in a lack of referrals and accountability for all parties involved). For example, in the HCT program, HIV-positive patients would often have to repeat testing in order to receive treatment (if the patient, for example, had lost his or her forms) and afterward would never get directed back to counseling by the medical community. HIV status forms were not shared between clinics and BOCAIP, and there was no means for tracking patients between the two. Similar issues occurred with the PMTCT program between the NGOs themselves, as there was again no universal means to track patients and their feeding processes. These issues were aligned with the shortfalls of social marketing and Jones 2004's "behavior change hypothesis," targeting individuals in specific demographics without incorporating or communicating with the greater community.

Culturally, as seen through observation of the True Love Waits meeting with BOCAIP, there was a communication divide between partners, donors, and the contexts of two very different cultures. Foreign approaches were often seen as outdated, culturally

out of context, and unsustainable for the needs of the community. This aligns with the notation that donors place an opportunity cost upon treatment without ever performing a 'cost benefit' analysis of prevention programs (Jones 2004). There needs to be an assessment of whether initiatives, especially initiatives rooted in Western science, are successful within the context of the community without underplaying or ignoring complex social dynamics specific to the culture such as stigma and unequal power relations (as seen between acceptance and awareness levels among men and women).

The research revealed that BOCAIP was, at the time of study, dependent on foreign aid for most of its programs. However, one exception did exist with the Kumakwane Poultry Project. This project was meant to help sustain BOCAIP's OVC program in the area. Through this income-generation project, there was less reliance and dependence on donor funding which helped to "localize" the initiative.

In addition, two U.S. funded behavior change programs; the Basha Lesedi and Be Faithful projects had particularly positive results. Both programs were structured around donor influenced intervention techniques and manuals, however, they were tailored to specific cultural and community needs. Through the incorporation and the collaboration between the donors, NGOs, local partners, and the communities themselves, both programs had positive feedback, with the participants themselves promoting the model's spread across the country. This was likely because of the unified message and effort put forth by community leaders, organizers, NGOS, and the international donors to promote these programs to the community as a whole. In these cases, everyone was involved with the effort and no single group was singled out or stratified against the rest of the community. Furthermore, the programs were restructured to fit within the context of the

specific community targeted, and thus could effectively and efficiently adapt to the needs of the area. Both Basha Lesedi and Be Faithful evidenced that donor funding and structure were aligned with local realities, and funding was effective and efficient. The only shortcoming of these two programs was that they were entirely dependent on donor funding and ended when funding ceased. Although they were highly successful in all other criteria compared, the scope of both programs was both small and limited due to limited funding. These programs were never expanded to other regions of the nation. This aligns with Halmshaw and Hawkins assertion that donors often tend to focus on piloted programs without discerning possible wider application or implementation. Donor funding, structure, and support that successfully incorporates the local values, tradition-based systems, and customs of the whole community will allow for programs to access the greatest capacity of benefit.

4.3 Conclusion

The results analyzed were in conjunction with literature reviewed. The data showed that BOCAIP runs programs with a diversity of effectiveness, efficiency and sustainability. BOCAIP's donor funding produces programs that are self-operating, self-sustaining, efficient, and beneficial to HIV and AIDS support as well as programs that do not encompass all or some of those characteristics. In the concluding chapter, the results analyzed will be considered within the broader context of the research questions presented and recommendations will be provided that aim to improve current approaches.

CHAPTER 5

CONCLUSION AND RECOMMENDATIONS

This study seeks to examine the complexities surrounding the impact and relationship between donor funding and local organizations, communities, and outcomes. Overall, the aim of the study was intended to assess donor-funded intervention strategies and their effectiveness, sustainability, and efficiency within the context of Batswana culture and community.

Dependence on donor aid was apparent for most sectors of BOCAIP, specifically among the projects that did not incorporate self-sustaining revenue projects. The majority of donor funding, structure, and support did not incorporate the whole community, but rather worked to single out certain "target groups of at-risk individuals." Two programs, PMTCT and HCT supported the arguments of Pfeiffer and Jones in 2004 (outlining the deficiencies of individually targeted approaches). On the whole, programs that addressed the community as a unit were surveyed and seen as far more successful among the recipients than programs that did not incorporate the greater community. These successful programs, Basha Lesedi and Be Faithful, helped to educate and create cooperative behavioral changes throughout the targeted communities. Priority needs to be placed on HIV-related programs focused on shared responsibility between donors and representatives of the receiving communities. This would allow broad-based community participation in HIV prevention planning.

In applying the research and analysis conducted with BOCAIP and its relationship with funding, the organization proved progressive and resolute in its mandate and ideals.

As the Botswana 2016 initiative draws closer to the goal of reaching a zero-new-incidence rate, so too does BOCAIP, as it plays a vital role in its contribution towards achieving this goal. Overall, BOCAIP has targeted effective ways to decrease HIV and AIDS incidence.

There are, however, a few suggestions that could be employed within BOCAIP as well as within the country itself to improve efficiency, sustainability, and effectiveness in HIV and AIDS policy and prevention practice. First and foremost, foresight and planning is a necessity for BOCAIP, as the arena of HIV and AIDS treatment and prevention methods change with the times.

As funding continues to decrease, BOCAIP must find avenues for self-sustainability and cannot rely solely on donor funding as it currently, almost exclusively, does. It could follow models currently employed in areas with a PCI initiative to create self-sustaining, income-generating projects, such as Kumakwane's poultry project, in order to help fund and sustain the NGO. As funding is spread thinner and thinner, BOCAIP's broad range of programs and projects also lose the valuable resources necessary for running successful prevention programs. Through re-examination of its mandate, BOCAIP could better focus and streamline the NGO, allowing it to be more efficient towards achieving its goals. This must be done by way of conducting analysis on the scope and success of current programs and whether they could be better unified, streamlined, expanded or eliminated. Returning back to its initial Christian ideals and focusing more fervently on counseling, especially couple's counseling, behavior change, and door-to-door home visits would be a means to achieving this goal. Furthermore BOCAIP should reexamine its programs by conducting cost benefit analysis. The

simplification of its objectives would help sustain BOCAIP's continuance and survival, as focused attention and funding would more efficiently target beneficiaries.

Organizations must place focus around the nature of the community in order to most efficiently, effectively and sustainably influence behavioral change. It is imperative that programs conduct extensive analysis to ensure that funding reaches the highest capacity of benefit.

Furthermore, funding should be examined within the context of the Batswana society. Focusing on the egalitarian, community-based values that have long been incorporated into Batswana tradition would translate to a more cohesive as well as a wider-spread response. Connecting communities with programs by engaging egalitarian values that stress community interconnectedness through kinship and shared resources in addition to the involvement of cultural leaders among others would allow for a cohesive network of individuals working toward the same goal. The many programs that impose western values, without considering differences in cultural values, fail to create a network that can influence the wider community. Western-based approaches must be reconstituted to align with local realities by using surveys and Batswana specific additions and changes to donor manuals and structures so as to better fit within the context of the beneficiary environment.

Better communication and coordination between NGOs and NACA, while aligning with Botswana's National Strategic Framework and criteria for reducing and eliminating new incidences of HIV and AIDS, is imperative for using reduced funding more efficiently and effectively. There is a need for better integration of key players in

the community to support current initiatives such as the chief, pastors, and officials. Turning the spotlight away from focusing solely on treatment, which does not efficiently reduce the number of new cases, and awareness campaigns, many of which are currently outdated, and instead directing attention more towards behavior change projects will allow Botswana to effectively reduce the new incidences of HIV and AIDS.

Donors must be encouraged to continue funding of successful projects, such as Basha Lesedi and Be Faithful, rather than piloted ones so as to more effectively make use of the limited aid and resources available. It is imperative that donors conduct a cost benefit analysis before dedicating funds to specific roles. Programs must take into account the ideals and social agendas of the communities. This is particularly important, as many traditional Botswana societies run based on the non-Western value of egalitarianism. Singling out any one group can cause great damage to the structure of the Botswana communities through the detrimental effects of stratification, stigmatization, and discrimination. These resulting effects lessen the success of such preventative programs. The programs need to unite with other NGOs and organizations through coordination, precision, and communication in order to create a cooperative network of individuals working towards a similar goal.

It is only through this foresight, perseverance, adaptive and strategic planning that foreign aid policy will one day produce total eradicative results of HIV prevalence in Botswana.

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APPENDIX

Focus Group Discussion Questions

1. If you had your own funding how would you restructure your programs?
2. Do you run your programs this way because you are dependent on donor funding?
3. Do you believe the National Strategic Framework is effective?
4. What changes should be put in place?
5. Do you believe we are headed to a future of zero new incidences in Botswana? What else needs to be done?
6. Comment more on conditions associated with donor funding and/or government funding.
7. What are the biggest issues or weaknesses with these donor/government partnerships that wouldn't exist if BOCAIP had independent, self-sufficient funding?
8. What are the challenges in communication with your partners and donors?
9. What are the realities around NGOs in Botswana in relation to funding, program effectiveness, etc.?
10. Do you have any local approaches you use in your programs currently (not determined by donors)?
11. If not, are there any local approaches you think could be put in place?
12. Are there any cultural barriers that hinder the effectiveness of your programs or programs

introduced by donors?

13. Any further comments?